TRANSMITTAL LETTER FOR MANUAL RELEASES

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
BENEFICIARY SERVICES ADMINISTRATION
DIVISION OF ELIGIBILITY SERVICES
201 WEST PRESTON STREET
BALTIMORE, MARYLAND 21201

MANUAL: Medical Assistance

RELEASE NO: MR-111
ISSUED: July 2003

EFFECTIVE DATE: Upon Receipt

APPLICABILITY: verification and documentation requirements, revised DES 401, emergency medical services for illegal/ineligible aliens, revised DES 501, waiver applicants in LTC

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COMMENTS

- The verification and documentation requirements in Chapter 4 and the Appendix are revised or clarified, including the following:
  - Verification from the applicant/representative (A/R) is only necessary if the required information cannot be obtained from databases or other sources, except that verification from the A/R is always required for income, resources, and third party liability.
  - A letter from the insurance company verifying the current cash value of life insurance is not required until the first redetermination of eligibility, if the estimated current cash value is quoted in the policy's amortization table.
  - For long-term care applications, the DES 2000 – LTC – Physician's Statement of Incapacitation and the DES 2004 – Representative's Statement are no longer required in order to authorize a representative to sign the application and act in the applicant's behalf.

- For the X02 State-only coverage group of illegal/ineligible aliens, the explanation of emergency medical services and the medical eligibility requirements are revised to clarify the covered services. The DES 401 form is revised to specify the information needed by DHMH for the medical eligibility review.

- The DES 501 form is revised to correct the DHMH address to which the form is sent to authorize payments of long-term care facilities for a less than 30-day stay.

- Policy Alert 10-11 is revised to clarify the role of the DHMH Division of Eligibility Waiver Services (DEWS) when a recipient is discharged from a long-term care facility (LTCF) into a home and community-based services waiver. The waiver case manager will be in contact with the LTCF to arrange for the discharge. The waiver administering agency will inform DEWS of the discharge date through the Authorization to Participate. The LTCF should send the discharge DHMH 257 to DEWS, rather than to the local department of social services.

- If a child is blind or disabled and because of age or incompetence is not able or permitted to sign, the parent with whom the child lives must sign for the child.

- The representative must sign for a blind or disabled child who does not live with his/her parents and who is unable to sign because of age or incompetence.

Verification Requirements

When an application is received, the local department of social services (LDSS) conducts system clearances (e.g., CARES, MMIS, SDX/SVES/SOLQ, MABS) to determine whether the applicant has current Medical Assistance coverage, to investigate what benefits or income the applicant or spouse is receiving, and to obtain or verify other information related to the application. Information provided by the applicant or representative (A/R) may be contradictory or different than information obtained from the clearances. If the LDSS eligibility technician (ET) has any reason to question the information presented by the A/R on the application or at the interview, or if the information presented is contradictory, incomplete, vague, or incomprehensible, the ET should request additional information or verifications from the A/R.

Verification by the A/R of the following information is always required in addition to the declaratory information provided by the A/R on the Medical Assistance application form:

- Income (except that SDX/SVES/SOLQ is used to verify Supplemental Security Income, Social Security, and Railroad Retirement benefits, so verification from the A/R is only requested if necessary)
- Resources
- Private health insurance or other third party medical coverage (request a copy of the front and back of the insurance card)

The ET should only ask the A/R for verification of other information if:

- The ET requires additional information in order to determine technical or financial eligibility (e.g., the information provided by the A/R is incomplete or unclear or there is a discrepancy);
- The ET has no other source to obtain the needed information or to verify certain information on the application; and
  The information or verification may have an immediate bearing on the case or may impact eligibility.

Due Date for Verifications

The LDSS must inform the applicant/representative (A/R) in writing of the required information and verifications needed to determine eligibility and the due date. The A/R, in turn, must provide all required information and verifications early enough for the LDSS to meet the 30 or 60-day limit. If an applicant does not provide the required information to

enable the LDSS to determine eligibility within the applicable time frame, the applicant may be determined ineligible. However, an extension of time standards is required of the LDSS under certain circumstances. For instructions on when to apply these standards, refer to section entitled "Extension of Time Standards".

Required Verifications

The various factors affecting eligibility that may require verification are listed, along with the method of verification, in this Manual's Appendix under "Verification/Documentation". While some factors can be verified in a number of ways, others (such as income and resources) require verification from a specific source. The following factors call for special comment.

As a general rule, written verifications should be signed and dated. The document should also include the name, address, and telephone number of the person providing the verification. LDSSs are authorized by the A/R's signature on a Consent to Release of Information form to contact a signatory and verify the validity of a statement.

SDX/SVES/SOLQ Verifications - The following information is verified by the LDSS through the State Data Exchange (SDX), State Verification Exchange System (SVES), or State On-Line Query (SOLQ). Hard-copy verification from the A/R is only necessary if there is any discrepancy.

- Date of birth
- Social Security number
- Supplemental Security Income (SSI) benefits
- Social Security benefits
- Railroad Retirement benefits
- Medicare entitlement and enrollment
- Medicare number

SAVE Verification of Alien Status – If the applicant indicates on the application or at the interview that he/she is a U.S. citizen, this declaratory statement does not need to be verified, unless there is a discrepancy. If the applicant indicates that he/she is not a U.S. citizen but is a legal entrant, the LDSS uses the Systematic Alien Verification for Entitlements (SAVE) system in order to verify the alien status, most recent date of U.S. entry, and date of qualified alien status. If no discrepancy is found, hard-copy verification by the A/R is not required. Verification of alien status either through SAVE or from the A/R is not required for an alien applying for only emergency medical services.

Residence may be verified by a rent book, rent receipt, gas/electric or telephone bill, statement from the landlord, etc. Whatever is used, it is essential that the verification source indicate that the applicant lives at a specific address. The address must be complete and the ET must determine if the address is in Maryland. For the homeless person, the LDSS must establish that the person has no permanent address in the Maryland or in any other state. Decisions as to whether or not such persons are Maryland residents must be evaluated on a

case-by-case basis.

Age – A birth certificate is only one of the acceptable methods for establishing date of birth. There are a number of other methods such as insurance policies or baptismal, confirmation, marriage, Social Security, employment, school, or military service records. However, when an age limit is reached within the calendar year, the A/R must also provide proof of the actual month of birth.

The Department of Juvenile Services representative for a child who is an applicant for Medical Assistance is not required to provide verification of the child's age. It may be presumed that the child is under 21 years of age based on the child's commitment to the DJS.

Earned income for persons, other than the self-employed, must be verified by pay stubs or a complete written, signed and dated statement from the employer showing weekly, biweekly, etc., gross earnings for at least the last month or 4 weeks (more if necessary when income varies). Either is acceptable. A self-employed person must provide acceptable records of gross earnings and expenses and/or a copy of the most recent valid tax return.

Life Insurance – When the applicant has life insurance with a cash value, a statement must be obtained from the insurance company on company letterhead paper that verifies all necessary information-- current cash surrender value, policy number, policy owner. For the applicant's initial eligibility determination, however, the ET may use the current cash value from an amortization table in the life insurance policy, if the policy has a table reflecting the estimated current value. Then, verification of the actual current cash value by the insurance company is required no later than the first redetermination of eligibility.

If mail to the insurance company is undeliverable and there is no way to contact the company, the Maryland Insurance Commission should be contacted to help locate the company or its successor. If the company cannot be found, any information available on the cash value of the life insurance may be used. If no information can be obtained on the cash value, the life insurance is excluded as a resource. If the A/R makes a good faith effort to obtain information on the cash value, the eligibility determination is not delayed or denied due to the inability to determine the current cash value of life insurance.

Representative - Since the Medical Assistance program does not require a representative to be legally authorized by a court in order to act on the applicant's behalf, it is not necessary to obtain verification of guardianship or Power of Attorney. Signatures on the Medical Assistance application are sufficient to authorize a representative acting on the applicant's behalf.

Application Signature Requirements

For the purpose of completing the application form and filing it for registration of the application date, the representative may sign and date it. However, since institutionalized persons are generally not seen by the ET, the institutionalized person, if competent, must sign the application before the LDSS determines eligibility. If the applicant did not sign the application before it is submitted to the LDSS, and the applicant is competent to sign, the LDSS must return the application to the institutionalized person for signature.

If the institutionalized person is incapable of signing the application but has a competent spouse with whom the person lived prior to institutionalization, the spouse must sign the application.

Assistance Unit Requirements

- When an application is filed prior to institutionalization and there are other family members in the home, the assistance unit will be structured in accordance with Chapter .06.

- When an application is filed for an institutionalized couple who share the same room in the LTC facility, separate case records and numbers as well as separate eligibility determinations are required.

Period Under Consideration

For an institutionalized person, the period under consideration must be adjusted when the person applies pending admission to a LTC facility or in the month of admission to a LTC facility. For details, refer to procedures for institutionalized persons in Chapter 10.

Verification Requirements Specific to Long-Term Care (LTC) Eligibility

The DHR/FIA 1052 – LTC – Request for Information to Verify Eligibility form is sent by the ET to the A/R, specifying information or verifications needed to determine LTC eligibility and giving the due date for receipt of the information. The following types of verifications are addressed on the form:

Application – The DHR/FIA CARES 9709 is used as the application form for Medical Assistance LTC eligibility.

Representative – The DES 2000 – LTC – Physician's Statement of Incapacitation is no longer required to be completed and signed by the applicant's physician, in order for a representative to sign the application and participate in the application process on the

applicant's behalf. Also, the DES 2004 – Representative's Statement is no longer required to be completed and signed by the applicant and the representative, in order to authorize a representative to act on the applicant's behalf. Since the Medical Assistance program does not require a representative to be legally authorized by a court in order to act on the applicant's behalf, it is not necessary to obtain verification of guardianship or Power of Attorney. Signatures on the CARES 9709 application are sufficient to authorize a representative acting on the applicant's behalf.

Consent to Release Information – The DHR/FIA 704 form is used for applicants to consent to the release of information. For LTC applicants, the DES 2002 form is also signed by the A/R to authorize the long-term care facility (LTCF) to release information to the LDSS related to the LTC application. The DES 2005 form is signed by the A/R to authorize the LDSS to release information about the application to a designated LTCF.

Medical Level of Care – In order for the LDSS to determine LTC eligibility, the applicant must be certified by DHMH's utilization control agent (UCA) to need the level of care provided in the LTCF for a period that includes the LTC application date. The LTCF initiates this process by having the applicant's physician complete and sign the DHMH 3871, which is sent to the UCA for a level of care determination. The UCA documents its decision on the DHMH 257, which is sent to the LDSS.

Demographic Information –

- The LDSS verifies an applicant's Social Security number and benefits and any Medicare number and enrollment by checking SDX/SVES/SOLQ. It is only necessary to request verifications from the A/R (e.g., copy of the Social Security card or Medicare card) if there is a discrepancy or the LDSS cannot otherwise obtain the required information.
- The A/R's declaration on the application that the applicant is a U.S. citizen is accepted without verification, and only needs to be verified by the A/R if there is a discrepancy. If the A/R reports that the applicant is a legal alien, the LDSS verifies the applicant's alien status through SAVE, and only requests verification if there is a discrepancy or need for additional information.
- It is necessary for the A/R to provide verification of the applicant's marital status, such as a copy of the marriage certificate or divorce decree. Maryland does not recognize common law marriage. A couple which is considered married under state law has a spouse-to-spouse financial responsibility until they have received a divorce decree or until one spouse dies.

Income – SSI, Social Security, and Railroad Retirement benefits are verified by the LDSS through SDX/SVES/SOLQ. MABS is available as an additional verification of the applicant's earned income. Otherwise, the A/R is required to provide verification for gross amount of each type of countable income received by the applicant. Earnings must be verified for the past month or 4 weeks. The ET may request additional verifications if necessary to determine the A/R's gross countable income. See the section "Verification/Documentation" in the Appendix of this Manual for examples of acceptable

income verifications.

Resources - If the spousal share has not already been calculated, resources of both the applicant and spouse must be verified for computation of the spousal share as of the beginning of the applicant's first continuous period of institutionalization. For determination of current LTC eligibility, the A/R is required to provide verification for the value of each type of countable resource owned by the applicant and/or spouse as of the 1st day of the month of application. Typically, the value of liquid assets (e.g., bank accounts) must be verified for the past 3 months. For non-liquid assets, the current, accessible value must be verified. The ET may request additional verifications as necessary in order to verify ownership and value. See "Verification/Documentation" in the Appendix of this Manual for examples of acceptable resource verifications.

The ET should require the A/R to provide resource verifications for selected months in the look-back period before the month of application if the A/R reports a disposal or if the ET has reason to suspect a disposal, and the disposal would result in a current penalty period. The ET decides how many months and at what intervals to check for disposal of resources in the past 36 months (60 months for a trust). The ET should require no more months of verifications than necessary to determine eligibility. To verify bank accounts or other investment accounts that closed during the look-back period, it may be sufficient to obtain only the final statement from the financial institution.

When it can be verified that the LTC applicant was a recipient of a needs-based public benefit at any time during the 5 year period before the month of application, verification of the value of resources during the look-back period is not required. Resources still need to be verified as of the month of application. However, when a disposal of resources is reported by the A/R or suspected by the LDSS, all pertinent verification must be provided by the A/R. Needs-based public benefits include but are not limited to:

- Supplemental Security Income (SSI)
- Cash public assistance (TCA, TEMHA, PAA)
- Community Medical Assistance
- Qualified Medicare Beneficiary (QMB)
- Specified Low-Income Medicare Beneficiary (SLMB) I or II
- Maryland Pharmacy Assistance Program (MPAP)
- Food Stamps
- Energy Assistance
- Section 8 or other subsidized housing from the U.S. Department of Housing and Urban Development (HUD)

Life Insurance – When the applicant has life insurance with a cash value, a statement must be obtained from the insurance company on company letterhead paper that verifies all necessary information-- current cash surrender value, policy number, policy owner. For the applicant's initial eligibility determination, however, the ET may use the current cash value from an amortization table in the life insurance policy, if the policy has a table reflecting

the estimated current value. Then, verification of the actual current cash value by the insurance company is required no later than the first redetermination of eligibility.

If mail to the insurance company is undeliverable and there is no way to contact the company, the Maryland Insurance Commission should be contacted to help locate the company or its successor. If the company cannot be found, any information available on the cash value of the life insurance may be used. If no information can be obtained on the cash value, the life insurance is excluded as a resource. If the A/R makes a good faith effort to obtain information on the cash value, the eligibility determination is not delayed or denied due to the inability to determine the current cash value of life insurance.

Real Property – The deed(s), the DHMH 4245 Physician's Report, and the DHMH 4255 Home Exclusion - Statement of Intent are sufficient to verify ownership of home property being considered for exclusion as a resource for a LTC applicant/recipient. It is unnecessary to verify equity value, unless the ownership interest changed during the look-back period (e.g., transfer to someone else or addition of new owners). Therefore, copies of the State property tax assessment and the mortgage agreement are only required if there was a change of ownership or if the applicant or spouse is trying to sell the property.

For real property not associated with the home, the equity value must be verified.

Verifications for Deductions from Available Income for the Cost of Care –

- Health Insurance – In order for the ET to deduct only the institutionalized person's health insurance premiums from the available income towards the cost of care, the ET needs either a recent premium bill or a canceled check for a premium payment, as well as a copy of the front and back of the health insurance card. If the ET has reason to believe that the premium being paid is for someone other than the institutionalized person, the ET can contact the insurance company to verify the policy's insured member(s).
- Residential Maintenance Allowance – It is not required to verify shelter expenses or obtain a copy of the mortgage, lease, or rental agreement. However, the DHMH 4245 Physician's Report and the DHMH 4255 Home Exclusion - Statement of Intent are required in order to deduct a residential maintenance allowance, if the institutionalized person intends to return to the home property.
- Spousal Maintenance Allowance – If the community spouse does not report shelter expenses on the DES 2003 form, the basic maintenance and shelter allowance is deducted for the spouse. The community spouse's income must still be reported.

- Members of foreign press, radio, film or other information media and their families.

Illegal Aliens

An illegal alien is any person not lawfully admitted for permanent residence in the U.S. These aliens either were never legally admitted to the United States for any period of time, or were admitted for a limited period of time and did not leave the United States when the period of time expired. This group includes persons residing in the U.S. illegally regardless of the means by which the alien arrived (e.g., border crossing by boat, train, car, bus, airplane or by foot).

2. X-Track - Coverage of Certain Aliens for State-Only Medical Assistance or for Only Emergency Medical Services

Certain "non-qualified" aliens who are not eligible for full Medical Assistance benefits in a federal category may be covered for full benefits in the State-only medical care coverage group of X01 or for only emergency medical services in the federal category of X02.

Children and Pregnant Women – Aliens (X01)

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 contained certain provisions restricting the eligibility of certain legal aliens for the federal MA Program. Covered for full MA benefits as State-only are children and pregnant women who arrived in the United States on or after August 22, 1996, meet the definition of "qualified alien", but fail the citizenship requirements for federal coverage. They are eligible for State-only MA if the

alien is:

(1) Younger than 18 years old;
(2) A full-time student and reasonably expected to complete a program of secondary education or the equivalent level of vocational or technical training before the end of the calendar year in which the child turns 19 years old; or
(3) Pregnant.

Emergency Medical Services for Illegal or Ineligible Aliens (X02)

A "non-qualified" alien, who fails to meet the citizenship requirements for full benefits under federal MA and who is not a child or pregnant woman eligible for X01, may be eligible for federal coverage of treatment of an emergency medical condition only. The illegal or otherwise non-qualified alien must meet all the financial and non-financial requirements of MA eligibility as defined in COMAR 10.09.24 and Chapters 5 and 9 of this Manual, except the technical requirements related to citizenship and a Social Security number (SSN). Note that the non-financial eligibility requirements for X02 do include Maryland residency. Please refer to the residency requirements in Chapter 5 of this Manual.

Explanation of Emergency Medical Services

A "non-qualified" alien may be covered under X02 if the alien has, after sudden onset, an emergency medical condition (including labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

- Placing the patient's health in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Maryland Medicaid considers emergency services as those services rendered in a hospital from the moment the individual presents with an emergency condition, to the time the person's condition is stabilized. The definition of emergency medical services includes labor and delivery services, but not routine prenatal or post-partum services. Emergency medical services include dialysis and related services for aliens with End Stage Renal Disease (ESRD), services for individuals with AIDS, and some cancer treatments.

Medicaid does not cover any medical services to treat and/or evaluate a condition for an individual who is an illegal/ineligible

alien if the services do not meet the definition of an emergency. Emergency services do not include medical support, medical equipment, or prescribed drugs that are required beyond the point at which the emergency condition is stabilized. Emergency services do not include any services related to any transplant procedure. Routine prenatal or post-partum care is not covered.

General Eligibility Requirements

1. Except for citizenship/alien status requirements and enumeration (Social Security number), all MA technical and financial eligibility requirements (including Maryland residency) for either the Families and Children (FAC) or the Aged, Blind or Disabled (ABD) coverage groups must be met for X02 coverage.

- These requirements include assistance unit requirements and the consideration of income and resources of assistance unit members. Also considered are the income and resources of the spouse of a member or the parents of an unmarried minor child (under 21 years old), if living in the same household.
- A person between the ages of 21 and 64 who is not the parent or caretaker relative of an unmarried minor child in the household (i.e., is not technically eligible under rules for the Families and Children coverage category) must be determined blind or disabled by the Social Security Administration or DHR's State Review Team in order to meet the technical eligibility rules for the Aged, Blind Disabled coverage category.
- The documentation of a person's immigration status is not required for coverage of emergency medical services. Also, aliens being considered for X02 coverage are not required to

provide or apply for an SSN.

2. Only the person with incurred expenses for emergency medical services may be certified in the X02 coverage group.

Medical Eligibility Requirements

1. Documentation of Emergency Services Other than Labor and Delivery Services. For an alien to be eligible in X02, the service received must be consistent with the Explanation of Emergency Medical Services above. The determination of whether the service meets the coverage requirements is determined by DHMH's review of the medical report about treatment received by the person. The medical report must be in sufficient detail to determine both the diagnosis and whether or not the treatment was of an emergency nature.

The documentation of the emergency nature of the medical services must include:

1. Diagnosis (or diagnoses) and
2. Description of treatment and
3. Dates of treatment and
4. MMIS Screen 1 or CARES/MMIS Inquiry Screen showing the results of a search for whether the applicant has a previous history on CARES or MMIS.

The following is a list of acceptable medical documentation:

- When the patient has been discharged:

  Discharge summary with admission and discharge dates.

- When the patient has not been discharged:

  Course of medical treatment, including admission date and tentative discharge date.

The following materials are unacceptable for medical documentation:

1. Bills
2. Nurses' notes
3. State Review Team (SRT) materials, including DHR 402B
4. Case record materials, including immigration documents.

2. Documentation of Disability

Since X02 coverage is available only to persons who would be eligible in a federal category but for the alien status, a disability determination by SRT is necessary if the person is applying as ABD and is not aged (65 or older). If the disability being reviewed by SRT is not related to the emergency medical treatment, the DHMH 4203 must be completed and submitted to SRT. However, if the condition which required the emergency treatment is the same as the disabling condition being reviewed by SRT, the record of the emergency treatment should satisfy SRT's medical documentation requirements, except that SRT must receive the DHR/FIA 707 transmittal form with the emergency treatment documentation.

In order to expedite the process if a disability determination is required, it is suggested that local departments not delay the SRT referral pending a determination of whether the services received meet the requirements of emergency medical services. However, regardless of the SRT decision, the applicant is not eligible if the emergency treatment criterion is not met. Conversely, the applicant is not eligible if the treatment was of an emergency nature but the applicant is not eligible in a federal MA category.

Documentation of Labor and Delivery Services

The applicant/representative must provide the LDSS with a copy of her Discharge Summary that is signed by her physician and also includes her name, admission and discharge date, and the course of her hospital stay.

Medical Eligibility Review Process

All services must be reviewed and approved by a medical professional within the DHMH Medical Care Programs before payment is made. Medicaid does not compensate for services that are not directly related to the injury or illness that caused the emergency. The approval will authorize payment for only those services necessary for treatment and stabilization of the emergency medical condition, not the full range of services covered under the Medicaid plan.

The medical report for determining medical emergency must be sent to:

DHMH, Beneficiary Services Administration
201 West Preston Street, Room L-9
Baltimore, Maryland 21201

Revised 2/02

Please mark envelopes: "Alien Emergency Services".

The DES 401 should accompany each report. The medical report will be evaluated by Program personnel to determine if the services received were for the treatment of an emergency medical condition. The local department will be notified of whether the services received meet that requirement.

NOTE: The medical eligibility review process does not apply to labor and delivery services. The LDSS will determine whether the woman meets the medical eligibility requirements based on the documentation of the labor and delivery services discussed above.

Certification of Eligibility for X02

If all eligibility requirements are met, certify on an OTO (one-time-only) basis the alien who has the incurred expense for the approved emergency service (including labor and delivery). Certify only for the month(s) in which the approved emergency service was received.

Denial of Eligibility for X02

Process in CARES the denial of an application for emergency medical services as specified on page 500-8g. Denial reasons relevant to X02 for the ET to include on the manual denial notice are:

- "The service provided was not emergency in nature"
- "Technically ineligible (non-federal)"

EMERGENCY SERVICES TO INELIGIBLE ALIENS

Date: _____

TO: Beneficiary Services Administration
Office of Operations & Eligibility
201 West Preston Street
Baltimore, MD 21201

FROM: Local Department _____
Medical Assistance Unit

Unit Address: _____

_____

_____

Case Worker's Name: _____

Telephone #: _____

SUBJECT: Determination of Emergency Services – Aliens

Case Name: _____

Case Number: _____

Date of MA Application: _____

I have checked and agree that the technical and financial information for the applicant has been reviewed and meets the MA requirements except for citizenship.
Caseworker Signature: _____
(Please sign your name)

The above-named applicant has submitted a Medical Assistance application for coverage of emergency services received from _____ (date) to _____ (date) at _____.

Attached please find a copy of the following:

- ❑ MMIS screen 1 or MMIS/CARES screen showing results of search
- ❑ Discharge summary with admission and discharge dates
- ❑ ER admission
- ❑ Documentation showing the emergency nature of the medical services

*Note: No bills or other extraneous information should be submitted.

MR-111
DES 401 (updated 7/03)

To: DHMH Division of Recipient Eligibility Programs
Room SS-7C
201 West Preston Street
Baltimore, MD 21201

From: _____
Local Department

Name of Recipient _____ M.A.I.D. _____
First M.I. Last

Name of Facility _____ MMIS Provider ID _____

Requested Begin Pay Date _____ Date of Discharge _____

☐ Recipient Certified under Spenddown.
Excess income remaining on first day of eligibility: $_____

Worker Signature: _____ Date _____

Telephone No. _____

DES 501 (Revised 7/1/03)

POLICY ALERT 10-11

MARYLAND HOME AND COMMUNITY-BASED SERVICES WAIVERS
Applicants Who Reside In a Long-Term Care Facility
EFFECTIVE: UPON RECEIPT

Medical Assistance (MA) recipients in a long-term care facility (LTCF) who have applied for a home and community based services waiver and meet all other medical, technical, and financial waiver requirements may not be enrolled in the waiver until they are discharged from the LTCF to a community–based setting. The DHMH Division of Eligibility Waiver Services (DEWS) is responsible for processing the MA waiver application and pending it in CARES. The following procedures will be used for institutionalized MA recipients who apply for a waiver.

If the applicant has already received a "Notice of Ineligibility" for MA waiver eligibility from DEWS, the applicant must re-apply if the applicant wants waiver eligibility to be reconsidered.

For pending waiver applicants, if the waiver administering agency (the State agency or other designated entity responsible for administration of the waiver) determines that the applicant meets all the non-financial waiver eligibility requirements except that the applicant still resides in a LTCF, the waiver administering agency will send an "advisory" Authorization to Participate (ATP) to DEWS. This ATP will specify that it is an advisory ATP because the applicant still resides in a LTCF. Upon receipt of the advisory ATP, DEWS will determine MA waiver eligibility.

If the applicant is not MA waiver eligible, DEWS will send the applicant a waiver denial notice, specifying the reason(s) for MA waiver ineligibility.

If the applicant is not MA waiver eligible, DEWS will send the applicant a waiver denial notice, specifying the reason(s) for MA waiver ineligibility.

If DEWS determines that the applicant appears to be MA waiver eligible based on the information provided so far, DEWS will send the applicant a waiver eligibility advisory opinion. The notice will inform the applicant that he/she may qualify for the waiver without reapplying, if he/she moves from the LTCF to the community within 6 months of the waiver application date (i.e., the date that the MA waiver application was received).

The local waiver case manager will follow up with the LTCF to establish the discharge date, and will assist the applicant with the necessary arrangements for community living. When the applicant is ready to leave the LTCF, the waiver administering agency will send an "authorization" ATP to DEWS, specifying the discharge date from the LTCF, confirming approval of waiver enrollment, and proposing a waiver enrollment date (usually the discharge date from the LTCF). The waiver administering agency will send a revised ATP to DEWS if the discharge date changes.

If the applicant moves out of the LTCF to a community home within 6 months of the application date, a new MA application is not necessary. The LTCF should send the discharge DHMH 257 to DEWS rather than to the local department of social services (LDSS) which has the MA long-term care case. If the applicant is MA eligible for the waiver, DEWS will close the MA LTC case and open the MA waiver case. DEWS will send the waiver approval notice to the

MARYLAND MEDICAL ASSISTANCE PROGRAM
APPENDIX
VERIFICATION/DOCUMENTATION

This Appendix contains information about verifications--when they are required and what is acceptable documentation. The types of documentation listed below are acceptable for verifying the technical and financial factors of Medical Assistance (MA) eligibility. The applicant/representative (A/R) should only submit a copy of the requested documentation, because originals will not be returned. Written statements of verification/documentation should be substantiated with the date as well as the name, address, and phone number of the person verifying the information. Verifications should be used in conjunction with one another to assure the credibility of all information used for determining MA eligibility.

Information presented by the A/R on the application may differ from information available on various databases (e.g., SDX/SVES/SOLQ, MMIS, CARES, MABS). If the LDSS eligibility technician (ET) has reason to question the information presented on the application or if the information presented is contradictory, incomplete, vague, or incomprehensible, the ET should request additional information or verifications from the A/R. The ET should only ask the A/R for verification of information on the application form if:

- The ET requires additional information in order to determine technical or financial eligibility;
- The ET has no other source to obtain the needed information or to verify certain information on the application; and
- The information or verification may have an immediate bearing on the case or may impact eligibility.

Verification by the A/R of the following information is <u>always</u> required:

- Income
- Resources
- Private health insurance or other coverage of medical services.

<u>Name and Identity</u>

The identity of the A/R and of each household member for whom benefits are requested must be confirmed. Name, Social Security number (SSN), and date of birth are used together to establish a person's identity. Household members who are not requesting benefits do not need to confirm their SSN, unless their information (e.g., income, resources) would affect eligibility and the ET questions their information.

Clearances using name and SSN (as well as date of birth, address, or other identifying information if necessary) must be conducted of MMIS, CARES, and SDX/SVES/SOLQ for the A/R and each person applying for benefits, to see if each person is known to the system. All discrepancies related to name, Social Security number, and date of birth must be resolved in order to establish identity. If a name given on the application is different in any way (spelling, middle initial, last name, etc.) from the name with that SSN on other databases, the discrepancy

must be resolved. The date of birth and relationship to applicant entered on the application may help to resolve who is who, especially when more than one household member has the same or similar name.

MMIS and CARES clearances must be conducted to determine if the A/R and each person requesting benefits already has a CARES and/or MMIS identification number, in order to prevent duplicate records being established for the same person. Therefore, a thorough clearance should be conducted using close approximations of the person's name (e.g., with and without the middle name or middle initial), to find any existing record. Original or subsequent entries may have been entered with a slight difference or typo (e.g., name or SSN entered incorrectly).

EXAMPLES OF ACCEPTABLE VERIFICATION FOR NAME AND IDENTITY:

- Social Security card
- Driver's license or automobile registration
- Birth certificate
- Immigration and Naturalization Service (INS) card
- Voter's registration card
- School enrollment papers or report card
- U.S. passport

Address and Maryland Residency

The assistance unit's residential address and mailing address are needed for contact information. The current residential address is also needed to verify that a non-financial requirement of MA eligibility is met—that the A/R and each person applying for benefits are Maryland residents (see Chapter 5 of this Manual for the residency requirements). The address declared by the A/R on the application does not need to be verified, unless the ET does not understand what is entered on the application or detects an error or discrepancy. If the application has an out-of-state home address or mailing address, the ET should require the A/R to verify the address and Maryland residency. Similarly, if other documentation (such as a bank statement) or a database clearance indicates a different address, the ET may ask the A/R for verification.

EXAMPLES OF ACCEPTABLE VERIFICATION FOR ADDRESS AND RESIDENCY:

- Recent rental or room and board receipts (with identifying address)
- Rental lease
- Voter's registration card
- Property ownership records (deed or mortgage payment records)
- Local Post Office records
- Driver's license or automobile registration

- Employer's records of home address
- Utility bill
- School verification

Marital Status

It is necessary to verify marital status. Additional documents may be needed for clarification of other issues, such as Assignment of Support rights, survivor's benefits, child support, alimony, etc.

EXAMPLES OF ACCEPTABLE VERIFICATION FOR MARITAL STATUS:

- Divorce decree
- Separation papers
- Marriage certificate
- SDX/SVES/SOLQ (marital status may be verified on Response Screen 7)

Social Security Number

The Social Security number (SSN) for the A/R and each other person applying for benefits should be checked by the ET through the SDX/SVES/SOLQ system. The person's name must match with the number. The SSN is not the Social Security claim number. MA has a non-financial eligibility requirement (see Chapter 4) that everyone applying for benefits must supply an SSN or provide proof that they have applied at the Social Security Administration (SSA) for an SSN. However, information about the SSN is not required and should not be verified for household members who are not requesting benefits.

EXAMPLES OF ACCEPTABLE VERIFICATION FOR SSN:

- Social Security card
- Paper receipt from SSA verifying the application for an SSN
- SSA 1099
- SSA letter or other SSA verification of SSN

Date of Birth

The date of birth can be verified through the SDX/SVES/SOLQ system. It is important for the ET to calculate and verify the age of the A/R and each other person applying for benefits. Age may affect how the ET handles the application and determines eligibility. It may impact who is included in the assistance unit, who may sign the application and apply for benefits, and certain income and resource exclusions and disregards.

EXAMPLES OF ACCEPTABLE VERIFICATION FOR DATE OF BIRTH:

- Birth certificate
- Baptismal certificate
- Church confirmation papers
- Military service papers

- Immigration papers
- Naturalization papers
- Hospital birth certificate
- Adoption record
- U.S. passport
- Voter registration card
- Family Bible or church records
- Marriage license
- Driver's license
- Bureau of Vital Statistics or State or Federal Census Record
- Liquor Control Board age card
- Employment ID card
- Life insurance policies
- Insurance company records
- Vaccination record
- Midwife's record of birth
- Alien registration card
- School records

Relation to Applicant, Race, Ethnicity, Gender

These are declaratory. Only "relation to applicant" could impact MA eligibility. There is no need to require verification, unless the ET detects a discrepancy or otherwise has questions about the information entered on the application (e.g., if the ET needs to clarify the living arrangements/custody of a child, etc.).

U.S. Citizenship or Alien Status

This is declaratory if the A/R indicates that a person is a U.S. citizen. The ET only needs to verify that a person is a born or naturalized U.S. citizen if there is any question or discrepancy (e.g., a previous CARES record or another database indicates that the person is an alien). If the A/R indicates that a person requesting benefits is not a U.S. citizen, the ET has to check the SAVE system for the person's current immigration status and determine whether the person meets the MA citizenship requirements (see Chapter 5 of this Manual). Citizenship/alien information is not required and should not be verified for household members who are not requesting benefits. The ET only needs to request verification from the A/R if there is any question or discrepancy that cannot be resolved through the available databases (e.g., SAVE). If an alien's most recent U.S. entry date was on or after August 22, 1996 and the person did not enter the U.S. as a qualified alien, the date of qualified alien status must also be obtained.

EXAMPLES OF ACCEPTABLE VERIFICATION FOR CITIZENSHIP/ALIEN STATUS (See Chapter 5 for additional types of alien documentation.):

- Birth certificate
- U.S. passport

- Certificate of citizenship
- Consular report of birth
- Certificate of naturalization
- INS alien registration card
- Immigration and Naturalization Form I-94 and Form I-551
- Social Security Number Issued Prior to June 30, 1948
- INS letter

Form I-551 ("green" card) has replaced Form I-a5a, but either form is acceptable as evidence that an alien has been admitted for permanent residence. The Form I-551 contains the lawful holder's photograph, fingerprint, and signature with blue printing superimposed over a white background.

Medicare

Verification of Medicare eligibility and/or the Medicare number is only needed from the A/R if the necessary information cannot be obtained from SDX/SVES/SOLQ or if there is a question or discrepancy (e.g., difficulty determining which information is for the A/R and which is for the spouse). The Medicare number may be different than the number on the person's Social Security card because the Medicare number must be followed by a suffix (e.g., A, W, D3).

EXAMPLES OF ACCEPTABLE VERIFICATION FOR MEDICARE ELIGIBILITY:

- Medicare card
- Medicare claim form
- Letter from SSA

Income

Each entry for earned or unearned income of the A/R and other assistance unit members (e.g., spouse, children) must be verified by the A/R. (See Chapter 7 of this Manual about determining income eligibility) The ET should also check SDX/SVES/SOLQ, MABS, and CARES for information about the income of each AU member.

Earned Income

The **gross** amount (before any deductions such as taxes) and the frequency must be provided for each entry of earned income for each AU member.

EXAMPLES OF ACCEPTABLE VERIFICATION FOR EARNED INCOME:

- If an AU member is **employed**, they must submit:
  - complete copies of the most recent and consecutive pay stubs for the past month or 4 weeks; **or**

  - a signed statement on letterhead from their employer giving the employee's name, date (month, day, year), Social Security Number, and gross pay or expected earnings for the next six (6) months; **or**
  - W-2 forms.
- An AU member's written statement may confirm tips, gratuities, or occasional income.
- If an AU member is **not** currently working, but has worked in the **last 6 months**, they must submit:
  - a statement from their former employer giving the last day worked; **or**
  - proof of application for unemployment.
- If an AU member is **self-employed**, they must submit a **signed copy** of their latest **federal and/or state income tax return and Schedule C** showing business profit or loss. If there are discrepancies or the ET questions how the amounts, additional schedules or other documentation may be requested.
- Employer's wage records
- Quarterly income tax forms for self-employed or AU members filing estimated tax returns
- Self-employment bookkeeping records

Unearned Income

A copy of the **current benefit statement** from the agency or company that provides each type of funds must be provided for each AU member with unearned income. Confirm that the gross amounts are listed. Do not use actual benefit checks, because they reflect the net payment after any deductions rather than the gross benefit. The ET should check SDX/SVES/SOLQ to verify any reported SSI, SSA, or Railroad Retirement benefit and MABS to verify any unemployment benefits. If necessary information cannot be verified through these systems, request other form(s) of verifications.

EXAMPLES OF ACCEPTABLE VERIFICATION FOR UNEARNED INCOME:

- Income tax returns
- Check stub, if it indicates the gross amount
- Letter from payer
- Award letter for each listed benefit
- Benefit statement
- Verifications for Social Security benefits:
  - Social Security award letter
  - Social Security (Form SSA-1610)
  - Letter from the Social Security Administration
- Verifications for other government programs—award letter or records:
  - Unemployment compensation award letter
  - Pension award notice
  - Worker's Compensation records

  - Veteran's Administration award letter
  - Railroad Retirement award letter
  - Civil Services annuity award letter
- Pensions, retirement, and other benefits income
  - Correspondence from the source of the benefit
  - Employer's records
  - Union records
  - Lawyer's records
  - Insurance company records
  - Lodge, club or fraternal organization records
  - Personal or income tax records-state and/or federal
  - United Mine Workers Union--Black Lung or miners' benefits
- Support Payments--The type of income as well as the amount and frequency must be provided. Supporting documentation such as receipts, child support enforcement forms, or a letter from the person giving the monies are acceptable documentation.
  - Divorce or separation papers
  - Alimony papers
  - Probation Office record
  - Court order/court record
  - Support agreements
  - Written statement of person making the contributions
  - Cancelled checks of person making the contributions
  - Income tax returns
  - Employer's records of attached wages for support payments
  - Child support enforcement information on CARES
- The **most current statement** from the financial institution must be provided showing payments of dividends, trusts, annuities, and all other investment income.
- In-kind Income
  - A written statement by the provider indicating what is provided, its value, and the frequency with which it is provided.
  - Household receipts (e.g., rent receipts, lease, utility receipts, food expenditure receipts)
- All other income (e.g., rental property income, income-producing property, farm produce, loan or mortgage with the AU member as the lender, boarders-lodgers) must be verified in writing, such as by:
  - Rental or lease agreement or records
  - Sales receipts
  - Contracts
  - Federal and/or state income tax return
  - Written statement from the entity making the payments

Resources

In general, resources are assets or accumulated wealth available to a person. Assets may be liquid (e.g., cash, bank accounts, stocks) or non-liquid including real property (e.g., land, buildings) or personal property (e.g., business property, household goods). An asset is evaluated in two ways: (1) value and (2) ownership interest. (See Chapter 8 about resource eligibility.)

The value of resources is considered as of the 1st moment of the 1st day of the month of application. The A/R must provide information and verification about all resources for all AU members. The ET should also check SDX/SVES/SOLQ and CARES for information about each AU member's resources. The home property in which the applicant or spouse lives is not considered a resource. The ET may request verifications for up to 36 months prior to the month of application or 60 months for a trust, if necessary to determine eligibility.

EXAMPLES OF ACCEPTABLE VERIFICATION FOR RESOURCES:

- Bank statement
- Legal document
- Letter from the bank or other financial institution
- Liquid Resources-cash on hand, bank deposits, checking and savings accounts, stocks, bonds, CDs, IRAs, Keoghs, other savings plans and investments, etc.: A current statement from the bank or other institution must indicate the amount and ownership of the resource, such as the following:
  - Checking account statements
  - Credit Union statements
  - Savings account statements
  - A stockbroker's written verification on letterhead of the values as of the beginning of the month of application, the share price, number of shares held, and if they are held only by the AU member or with others
  - Stock certificates
  - Bond certificates
  - IRA/Keogh—current statement from the financial institution or employer
  - Financial institution statements
  - Securities
  - Annuity—copy of the annuity document
- Trust funds are counted as an asset, unless the AU member can submit proof that the funds are inaccessible. A copy of the entire trust fund document including all appendices and attachments must be submitted to the ET.
- Deed for life estate
- Judgment and lien records
- Mortgage contract for rental or business property
- Life Insurance
  - Insurance policy
  - Written statement from insurance company

  - Insurance payment book
  - Employer's insurance records
  - Lodge, club or fraternal organization records
  - Information from relative or friend who holds policy for beneficiary
  - Union records
  - Veterans Administration records
- Burial Funds, Accounts, Contracts, and Spaces
  - Burial contracts
  - Burial reserve agreements
  - Burial agreement with funeral director
  - Lodge, club or fraternal organization records
  - Information from relative or friend who holds plan for beneficiary
  - Union records
  - Veterans Administration records
- Real Property
  - A property tax statement must be submitted for any non-home real property owned by the AU, either by themselves or with others
  - Deed
  - Sales agreement (settlement sheet)
  - Mortgage agreement
  - Real estate tax receipts
  - Income tax return
  - Court House records
  - Title Search
  - Utility company records
  - Financial institution statement
  - Appraisal
  - Current tax assessment
  - Sales records from similar properties in the geographic area

Insurance or Other Coverage for Medical Services

It is important for the ET to determine whether A/R and each other person applying for benefits has any other coverage or payer for medical services. If the A/R indicates that there is coverage, the ET must determine who is covered under the policy and whether the policy is active and covers medical services. Databases should also be checked for whether any third party coverage is indicated.

EXAMPLES OF ACCEPTABLE VERIFICATION FOR THIRD PARTY LIABILITY:

- Health or pharmacy insurance or discount card—copy of front and back
- CHAMPUS card
- Pay stub indicating insurance deductions

- HMO membership card or contract
- Court order for health insurance coverage by an absent parent
- Insurance policy
- Cancelled checks for medical insurance in conjunction with other insurance documentation, in order to verify the date and amount of premium payment
- Written statement from the insurance company
- Court documents, workers' compensation letter, or attorney's statement on letterhead indicating the status of any third party liability from an accident, or other incident in which someone other than the A/R may be responsible for payment of medical services. This information must then be referred to the Division of Recoveries and Financial Services.

Disability

For a person applying for benefits as a disabled or blind person, the ET must find out whether the person is currently determined to be blind or disabled by the Social Security Administration (SSA) or by the Department of Human Resources' State Review Team (SRT). SDX/SVES/SOLQ should be checked for whether the person is currently approved for federal benefits (even with a benefit of $0) related to blindness or another disabling condition (i.e., receiving Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI)). If not, paperwork must be completed and submitted to SRT for a disability determination.